# (Pseudo) "Exclusive" Contracts: An Insidious Business Practice that Selectively Damages IR

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Semin Intervent Radiol 2019;36:43–45

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## Abstract

Contracting is an important part of running the business of private practice interventional radiology. A basic knowledge of contracting is vital for the practicing interventionalist to best position him or herself to excel in private practice. Exclusive contracts are common in interventional, diagnostic, and radiology practices. Such contracts, however, may significantly limit the practice of individual interventional radiologists and impede the growth of interventional procedures in communities at large. This article outlines the role of exclusive contracts in interventional practices, and describes the limitations of such contracts.

**Keywords**
- interventional radiology
- contracts
- private practice
- legal

## History and Legality of Exclusive Contracts

Historically, exclusive contracting has been offered by hospitals typically to hospital-based specialties such as anesthesia, emergency medicine, pathology, and radiology. The legality of exclusive contracts, when challenged, has been upheld by courts based on arguments of administrative efficiency and coordinating utilization of costly hospital resources. Furthermore, groups seeking these contracts have suggested that the practice allows them to provide undervalued services to the hospital and its community and not have to contend with high valued procedures being "cherry-picked" away.[1,2]

Whether one agrees with the legitimacy or validity of any or all these arguments, one fact is certain; these arguments can only be made if a contract is truly exclusive. This means it bars *all* noncontracted practitioners, regardless of specialty, from providing the services protected by the exclusive contract. Put another way, exclusive contracts are to make certain services exclusive to the contract holder and prevent all other physicians regardless of specialty from providing these same services. Further, exclusive contracts typically are not enforced selectively based solely on a physician's board certification. This is because so many different specialists can perform procedures that at one time may have been the domain of only one specialty. For example, a radiology exclusive contract would not be used to only stop other board-certified diagnostic radiologists from reading magnetic resonance images (MRIs) of the spine but also any neurologist, neurosurgeon, or orthopedic surgeon. The contract would prevent all physicians outside of the scope of the contract from reading MRIs of the spine.

## What Is a Pseudo-exclusive Contract?

This leads us to the concept of "pseudo-exclusive" contracts. These are contracts that are termed "exclusive," but in fact have carved out portions of services and allow multiple other specialists to perform these services despite an "exclusive contract" being present. Where this most typically is encountered is for interventional radiology (IR)-type procedures included in diagnostic radiology (DR) contracts. In this situation, the hospital allows multiple other specialties to perform procedures that in the past were the domain of IR. For example, peripheral angioplasty and stenting, which was pioneered by IR and had IR as the dominant specialty providing the service in the 1990s, has seen a shift to cardiology and vascular surgery becoming the dominant specialties providing such services. This shift would not have been possible if these other specialties would have been barred from performing these procedures in the hospital because of exclusive contracts. In fact, in the early 1990s, vascular surgery specifically targeted methods to break radiology exclusive contracts and allow vascular surgeons the ability to perform endovascular procedures.

**Issue Theme** A Private Practice Perspective; Guest Editor, Manish K. Varma, MD



**DOI** https://doi.org/10.1055/s-0039-1679947.
**ISSN** 0739-9529.

So, although DR exclusive contracts have for the most part prevented other specialties from interpreting diagnostic imaging studies, they have not protected IRs from competing specialty "turf" intrusions. Even today, more incursions from outside specialties into classically IR procedures are occurring such as trauma surgeons performing trauma embolization, gynecologists performing uterine artery embolization, urologists performing nephrostomy tube insertions, etc. As exemplified in these examples, there is no real protection offered by "exclusive" contracts to IRs.

## Uneven Application of a Standard

The sad reality, however, is these same pseudo-exclusive contracts held by DR groups that allow vascular surgeons and cardiologists to perform peripheral angioplasty, and allow neurosurgeons, orthopedists, and pain management doctors to do kyphoplasty, etc., are used to block qualified interventional radiologists not party to the contract from obtaining staff privileges and performing these same procedures within the hospital.

This is incongruous with all reasoning and with any legal interpretation of the legitimacy of an exclusive contract. Exclusive contracts are for a defined set of procedures or utilization of specific hospital facilities for the express reason to improve health care delivery within the institution. They cut across all specialty lines and are not to exclude only one specialty. If other physicians, in other specialties, may perform a procedure in the hospital in a different location or in the same location as the "exclusive providers," any justifications or arguments used to validate the enforcement of the "exclusive" contract are lost. There is no improved efficiency obtained or easing of administrative burden or controlled utilization of hospital resources, as now a myriad of physicians provides the services. Barring only one subset of practitioners (IRs) does not reestablish the arguments that have been surrendered by allowing any other qualified specialist to perform the services. This nuance regarding "exclusive" contracts being enforced selectively against only a certain specialist while allowing other specialists to perform the same procedures has never been legally challenged. As legal challenges are fact specific, there is a strong possibility that if such a carved-out exclusive contract with an uneven application of a standard were challenged, the armor of "exclusive" contracts would fail in this specific area.

## Effects of the Field of IR: Beyond the Parochial View

These pseudo-exclusive contracts are not only problematic at a local level but have dramatic negative effects on the ability of IR as a specialty to evolve. Currently, there has been increasing interest by IRs to practice as close to 100% IR as possible (with fewer diagnostic responsibilities). This has led IRs to explore career options different from the traditional IR as part of a DR group. These include IR-only practices, freestanding IR opportunities, solo practice, and multispecialty practices. Unfortunately, because of these "exclusive" hospital contracts, today the only place an IR can realistically find a job is within a DR group that holds one of these contracts. Even if an IR wished to be solo or work in a multispecialty group outside of DR, this would not be possible as the DR group would (and does) prevent the IR from obtaining staff privileges at the hospital. Hospital privileges are required in many states even if one is performing only outpatient procedures in a freestanding facility. Furthermore, most insurance companies require staff privileges to be part of a network and obtain reimbursement. Therefore, attaining staff privileges is necessary in almost every conceivable employment scenario. If staff privileges at a hospital cannot be obtained, then the IR cannot practice their specialty. The presence and acceptance of these "exclusive" contracts as legitimate reasons to deny IRs privileges severely limits the available jobs for our newly graduating IRs or IRs changing positions.

## "I Have Met the Enemy, and He Is Us"

It is tremendously disappointing to realize that IR has made such major shifts in practice patterns and culture to survive turf wars from outside threats and become a vibrant clinical specialty, but have its future stifled not by outside forces but from within the house of radiology. Luminaries like Charles Dotter[3] in 1968, Katzen,[4] Rösch et al,[5] Roberts,[6] and Dake[7] all have stressed the importance of developing clinical practices and caring for patients longitudinally if IR is to survive and thrive. For the most part, the IR community has responded, and in fact new training programs and paradigms that embrace clinical practice have been adopted. All this has culminated in IR now being recognized as a primary medical specialty, and no longer a subspecialty of radiology.

In order for this evolutionary process to continue, the ability to practice clinically cannot be inextricably linked to contracts held by DR groups. In 1994, Katzen[4] suggested that "protectionistic radiology contracts" may need to be abandoned to allow "full-time interventionalists" access to hospitals to provide services to hospitals. In 2004, Rösch et al[5] stated "we (IR) need to stand separate from DR." Diagnostic radiologists and other IRs should not be preventing noncontracted IRs from practicing and performing the same procedures that the "exclusive" group allows other specialties to perform. No other primary medical specialty has its ability to practice medicine controlled so specifically by another specialty. This should not be interpreted as an absolute indictment against IRs having a fruitful relationship with DR. Quite to the contrary, many successful IRs can and do find professional satisfaction within a DR group, but that should not be the only place IRs can practice. IRs should have a choice as to the type of practice they have, who their partners will be, and where they will care for the patients. These decisions should be made by the individual IR (just as they are by individual surgeons and cardiologists), and not by a contract that is only used to stop "other" IRs.

## Truth Stranger than Fiction

Recently, a medical practice hired two new graduates, both starting the same day. One was a fellowship-trained IR and

the other was a fellowship-trained invasive cardiologist. Both physicians applied for staff privileges at the local hospital requesting privileges to perform peripheral angioplasty and stenting (no imaging privileges were requested). The invasive cardiologist was admitted to the medical staff, was granted privileges and access to the IR laboratory to perform angioplasty and stenting of the legs, while the IR was not allowed on the medical staff and was denied privileges on the grounds that an exclusive contract was in place. The irrationality of the logic employed to make this decision is utterly incomprehensible. How does this author know this? Because it was his own practice that hired them!

## What Would Dotter Do?

Many years ago, Charles Dotter received a request for a left femoral arteriogram with explicit instructions *visualize but do not try to fix*. Had Dotter succumbed to the pressures around him and propagated the status quo, IR would not be as unique and vibrant as it is today.

As individuals it is sometimes easy to say, "this doesn't affect me currently, so I don't need to pay attention to it," or "this is a bigger issue and I can't do anything about it." That is not the way IRs think; rather, they innovate and get tasks accomplished despite the odds being against them. Individually and as a specialty, IRs need to do everything in their power to ensure the viability and vitality of IR. Clearly, continuing the practice of using contracts to selectively block only IRs from doing procedures while allowing all other specialists to perform these same procedures is fundamentally flawed and damages IR as a specialty. In fact, if it were any specialty other than radiology blocking IRs from obtaining these privileges, the hue and cry to change the practice would be deafening.

If Dotter was alive today, one must question what he would do if he was told he wouldn't be allowed on staff to perform angioplasty, but every cardiologist and vascular surgeon in the area could get privileges to do these procedures?

As innovators, IRs must not accept the status quo but must work to improve it, not only for themselves but for future generations of IRs. Opportunity and choice should be in the hands of the individual IR and therefore all efforts should be made to rid the specialty of (pseudo)exclusive contracts and relegate them to a historical footnote in the evolution of the clinical practice of IR.

Conflict of Interest
None.

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